## Exhibit 19

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UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE) STEP 1 AND/OR STEP 2 EXAMINATIONS

ADMINISTERED TO STUDENTS/GRADUATES OF FOREIGN MEDICAL SCHOOLS BY

THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES, 3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, USA
PHONE: 215 386-5900 CABLE: EDCOUNCIL,PHA
PART A

NOTE: All items on all	sides of the application must be filled out completely for Initial and reexamination or application will not be accepted.  Use typewriter or block print in Ink.						
① ECFMG EXAMINATION	Have you ever submitted an application to ECFMG for any examination, even if you did not take the examination?  If yes, enter your USMLE identification Number (ECFMG Applicant Number) In this box.						
HISTORY:	NZ ves   No - 0-553-258-5						
② NAME:  Print your name as you want it to appear on the Standard ECFMG Certificate and on your official USMLE	T O H N   Middle Name						
	Last Name (Surname)						
record	Full Maiden Name (For married women only)						
(2.1) If you have previously applied to ECFMG under another name, provide that name	Previous Name Please include a copy of the legal document that verifies this name change.						
③ ADDRESS:	151 181 101 101 QILLIAINITIRIEILILI IAIVIEINILLE III						
Use address to which admission permit and other notification from ECFMG should be sent	Apartment Number  Post Office Box Number						
\$ P	City, OCANA A STATE OF THE STAT						
4 U.S. SOCIAL SECURITY AND/OR	Enter U.S. Social Security Number Enter National Identification Number and Country						
NATIONAL IDENTIFICATION NUMBERS:	Gountry:						
(5) STATUS OF MEDICAL SCHOOL STUDENT:	If you are applying for Step 1, will you have completed two years of medical school by the date of that examination? Yes 🔲 No						
Must be completed by students.	If you are applying for Step 2, will you have completed or be within 12 months of completion of the formal didactic curriculum at your medical school by the date of that examination?  Yes No						
REGISTRATION:     Select no more than	Step 1 Step 2 ECFMG English Test (Check one box only) (Check one box only) (Check one box only)						
one box for each Step and/or ECFMG English test for which	☐ June 11-12, 1996 ☐ March 5-6, 1996 ☐ March 6, 1996  Of Of Of						
you are applying.	October 15-16, 1996 August 27-28, 1996 August 28, 1996						
6.1) TEST CENTER: Select three different	If your center selections are not available, ECFMQ reserves the right to assign a center.						
ECFMG centers in order of preference for each Step and/or	Step 1: (1) City Center No. (2) City Center No. (3) City Center No.						
ECFMG English Test. See the Information	~Stepse						
application was enclosed for a list of ECFMG centers 1220	English Test: (1) City Center No. City Center No. City Center No.						
TEXAMINATION & A	Fees must be paid in United States funds. Checks, bank drafts or money orders are to be						
FEE(S): VI (	step 1 Basic Medical Science Examination \$440						
enclosed on the line provided	Step 2 Clinical Science Examination . \$440 ECFMG English Test \$40						
	Enter amount enclosed \$ TTU/CVEAU FOR OFFICE USE ONLY						
® HANDEDNESS:	Right Handed Left Handed						

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With the second	PART 8						
(9) SECONDARY SCHOOL/	List any secondary school, college, or university attended	Dates A From	No. School				
COLLEGE UNIVERSITY ATTENDED:	Name City/State/Country UNIVERSITY OF Benin. No	1081	10 PA.	Vears Out			
ETT-	Name City/State/County/ NGS COLLECTE L'AGOS MCE)	100574	0679	Sun			
10 MEDICAL DEGREE AND	NRGC	xpected: * MO.	10 YR. {	37.			
10.1 MEDICAL SCHOOL:	Name of Medical School from which you graduated or expect to graduate.  LIST, EXACT NAME AND ADDRESS.  LIVEYS IT OF THE NIN.	Dales Al From Mo. YR.	Ilended : To MO, YA.	No. of Years Attended			
	City/State/Country STATE NIGERIA.		1081	1087	6		
(0.2) OTHER MEDICAL SCHOOLS	Name City/State/Country Name	Name City/State/Country					
ATTENDED:	City/State/Country  Name City/State/Country	S = 10/4 5 EUT					
(0.2) CLINICAL CLERKSHIPS:	Clinical Discipline Hospital/Clinic Lecation (exact addr	ess)	Supervis Physicia		Dates of lerkship		
(1) MEDICAL LICENSURE: Present or Future	Date you received (or expect to receive) an unrestricted license or certificate of full registration to practice medicine:  MO. O YR. Country or state in which you are licensed:  * If the license has been issued, a photocopy must be sent to ECFMG. See Medical Education Credentials section of the ECFMG information						
12 HOSPITAL TRAINING: Residency or fellowship	Hospitals	on(s) Dates		-			
(3) EMPLOYMENT: Present employment only	Institution/Company Name: Street:	Pos	sition Dates		9		
14 BIRTHDATE/ BIRTHPLACE:	Day Of Month DI Year 59 Location: BENIN, LITY EDD STHTE						
15 GENDER:	Please check one: Male Female	the state of the s	Province, Country	)	activities desired		
17 CITIZENSHIP:	Please check one:   Male Female   ONATIVE LANGUAGE:   ONATIVE LANG						
B OTHER EXAMINA- TION HISTORY AND APPLICANT NUMBERS:	Check below the organizations to which you may have applied previously; enter the date of the most recent examination that was administered to you and the identification number that was assigned to you by that organization.  ORGANIZATION  DATE OF MOST RECENT EXAMINATION TAKEN  APPLICANT IDENTIFICATION NUMBER						
	NATIONAL BOARD OF MEDICAL EXAMINERS MO. YR.						
		JSMLE Steps 1/2		]-[			
i (50)	STATE LICENSING AUTHORITY IN THE UNITED STATES MO. YR.	FEDE FLEX	RATION IDENTIFIC	CATION NUMBE	ff (FIN)		
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,	PART C		ECF	MG-000644			

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	STATE LICENSING AUTHORITY IN THE UNITED STATES	MO. YR.			
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	Students and graduates must sign	PART C	recence of their Madical	· · · · · · · · · · · · · · · · · · ·	
# # # # # # # # # # # # # # # # # # #	Students and graduates must sign to School Dean, Medical School Vice Dea	an, or Medical School Re	egistrar. (See A below.)	The second of the st. 1	-
	If a graduate cannot sign the application cial noted above, he/she must sign the Official, First Class Magistrate or Now writing why the application form couschool official. (See B.1 below.)	e application form in the stary Public (See B bel	presence of a Consular ow) and must explain in		
	Application forms are to be mailed to who witnesses the applicant's signat		of the official or notary	V E	1
	All information on the application for the Educational Commission for Fore				1
(19) CERTIFICATION BY APPLICANT	I hereby certify that the information in my knowledge and that the photographs I also certify and acknowledge that I tains to the administration for which I are on ECFMG Certification and Application USMLE Bulletin of Information, am aw eligibility requirements set therein.  I understand that (1) falsification of the educational documents to ECFMG, or ments to other agencies, or (4) the greaters.	s enclosed are recent phi- have received the curre m registering) of the con- in for USMLE Step 1 and ware of the contents of b his application, or (2) the (3) the submission of a	ptographs of me. Int edition (that which per- bined Information Booklet I Step 2 examinations and oth sections and meet the submission of any talsified by falsified ECFMG docu-	DEAN COLLECTION OF CONTROL OF CON	JE)
	evidenced either by observation at the my answers and those of one or more in other conduct that subverts or attensufficient cause for ECFMG to bar me fin the examination, to withhold and/or in a certificate, to revoke a certificate, or Booklet for additional details concerning I understand that the ECFMG certificate was not eligible to receive of the Certificate was not eligible to receive	time of the examination other participants in that npts to subvert the examination, to malidate the results of not take other appropriately Validity of Scores and Inficate and any and all ced to ECFMG if ECFMG.	or by statistical analysis of examination, or engaging mination process, may be terminate my participation, y examination, to withhold a action. (See Information regular Behavior.) oples thereof remain the determines that the holder	Management of the second	* *
RECEIVE AUG 3 0 1996	i hereby authorize the Educational Comit any information contained in this appavailable to ECFMG, to any federal, stany hospital or to any other organization a legitimate interest in such information.	ommission for Foreign N plication, or information t ate or local governmenta n or individual who, in the	edical Graduates to trah M hat may otherwise become I department or agency, to		ı
ECFMC	Signature of Applicant X (In Latin Characters)	-175 Mar of 1/31	C/10000	Date	
(93) CERTIFICATION BY MEDICAL SCHOOL OFFICIAL OR	A. I hereby certify that the photograpply to the individual named about	x Signadoro	JOHDE	10 of this form accurately  Latin Characters)	'nn
	Official Title	Date	7	- / Institution	100
CERTIFICATION OF IDENTIFICATION WITH EXPLANATION (Pertains to graduales only)	I certify that on the date set forth     this applicant by: (a) comparing     by the applicant and with the ph     on this form with the signature     sworn to before me by the applic	nhis/her physical appea otograph affixed hereto on his/her identifying o	rance with the photograp and (b) comparing the ap focument. The statemer	on the identifying document popularity in the signature made in my ports in this document are subscri	resented presence
FOR OFFICE USE ONLY				,	
FORM DATE	Signature of Opnsular Official, First C	lass Magistrale, Notary t	Public (in Latin Characters)	Official Title	_
S.A.					
I.D.	B.1 Explain in the space below why	the application could	not be signed in the pre-	sence of your medical school de	ean vice
338	dean or registrar. Any explana	ation must be accepte	ble to ECFMG and mus	t be provided each time you s	ubmit an
339	application to ECFMG.		,42		
325					
RM-M9/1184	ĵi)	5:	5		
authority, or has any such I	d licensure or authority to practice medi license or authority to practice medicine on is "Yes," please explain fully on a ser action taken; and provide any supportir	e ever been suspended parate sheet of paper. (	ot tevoked t	Yes No	
(31) Provision of the following is	nformation is voluntary. The information	will be used for resea	rch purposes only. You ar	re encouraged to provide the infe	ormation;
however, the processing of Select the one which	f your application will not be affected if y	you choose to leave its 2	in & Diank.	5 🗆	6 🗆
best describes your racial/ ethnic background.	American Indian/ A Alaskan Native Pacilic	sian Hispani Islander	c Black (not of Hispanic Origin)	White (not of Hispanic Origin)	Other
		5 (RAV		ECEMG-000645	

	41	PA	RTD				***
(0.2) CLINICAL CLERKSHIPS:	Clinical Discipline	Hospital/Clinic		Location (exact addr	) 998)	Supervising Physician	Dates of Clarkship
Refers to that period of medical education in the clinical disciplines during	medicine	specialist	Hosp.	Blun	Warri	Dr Chwall	1988
which as a medical student you gained practical experience in hospitals or clinics.	Pediatrics	specialist	Hasp /	Benn	wwwi	Dr Asemota	1987-11
List clerkships (rotations, pre- graduate internships) for each clinical	OBGHN	s pecialist	1600	Ral	10//	De lying	10000
discipline.	000 900	3 Petitor	KIZSP	Seni	Whrit	Dr Winto	1988
ä	Surgery	s/pecialis)	· Hosp	Zem	Henn	In Idublia	1988
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